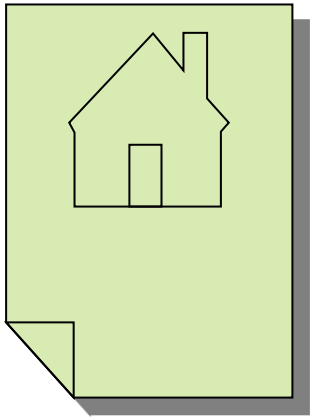
MONTANA
Department of Public Health & Human Services

Home and Community Based Services (HCBS) Program for the Physically Disabled and Elderly

also known as Medicaid Waiver



HCBS Program Description

"Nursing home without walls"

The program allows individuals, who would otherwise be institutionalized, to live in their own home and community. Individuals in the HCBS Program have the freedom to choose from a menu of services, those which will best meet their needs.

What is a Waiver ?

Under section 1915(c) of the Social Security Act, states may request waivers of certain federal requirements in order to develop Medicaid-financed community-based treatment alternatives. The three requirements that may be waived are:

- Statewideness,
- Comparability of services, and
- Community income and resource rules for the medically needy.

What is a Waiver?

Federal regulations permit HCBS waiver programs to serve the elderly, individuals with physical disabilities, developmental disabilities, mental retardation or mental illness.

To receive approval to implement HCBS waiver programs, state Medicaid agencies must assure the federal government that, on an average per capita basis, the cost of providing home and community-based services will not exceed the cost of care for the identical population in an institution.

Montana's HCBS Waivers

- Montana has four waivers:
  - Developmentally Disabled
    - Children and Adults
    - Disability Services Division
  - Elderly and Physically Disabled
    - Children and Adults
    - Senior & Long Term Care Division

Montana's HCBS Waivers cont.

- Severe Disabling Mental Illness (SDMI)
  - Adults age 18 or older
  - Addictive & Mental Disorders Division

- Psychiatric Residential Treatment Facilities (PRTF)
  - Youth ages 6 through 16
  - Health Resources Division

Eligibility for the Elderly/PD Waiver

1. Individual must be Medicaid Eligible – transfer of assets are also reviewed;

2. Meet nursing home level of care; and

3. Be elderly (age 65), or physically disabled determined by the Social Security Administration.

Not an entitlement program.

HCBS Services

- Basic Services – personal assistance, meals, homemaker, emergency response systems.
- Adult Residential – assisted living facilities, adult foster homes, residential hospice.
- Group Homes for physically disabled.
- TBI Services – residential rehabilitation in hospital, supported living.
- Vent Dependent – 24 hour private duty nursing.

Non-Traditional Services

- Assistance with cleaning home
- Supervision or socialization
- Remodeling a home to make it wheelchair accessible
- Environmental control units to automate home
- Modify vehicle (mostly vans) to accommodate disabled individual
- Service animal

Top Ten of the 40 HCBS Services

- Adult Residential
- Personal Assistance
- Case Management
- Supported Living
- Homemaking
- Private Duty Nursing
- Traumatic Brain Injury
- Respite
- Specially Trained Attendant
- Environmental Modifications

How It Works

- Individual is referred to Mountain Pacific Quality Health for a level of care screen.
- MPQH refers individual to the appropriate case Management team(s) made up of RNs and social workers.
- Team admits individual when slot is available.

How it Works

- Individual and Team develop a plan of care.
- Teams arranges for provision of selected services with providers.
- Teams prior authorizes services with ACS.
- Teams monitor care.

Prior Authorization (PA)

- The case management team authorizes services for six-months to one year. They may authorize for a shorter date span for one time purchase of equipment or modification.

- Dates of service on claim must be within date spans on prior authorization.

- Dates of service must also be within the recipient's HCBS waiver span.

Prior Authorization (PA)

- Claim may partially pay if units/dollars billed are more than units/dollars remaining in PA.
  - Verify number of units/dollars you have billed during the PA span to make sure you didn't over bill on a previous claim(s).
    - If over billed, you must submit adjustments to correct claim(s).
    - If not over billed, call case management team to notify them there aren't enough units/dollars in PA.
    - After PA is corrected, submit an adjustment on the claim that didn't pay correctly to re-price the claim.

Referral Form

- The case management team may make initial referral by phone to set up services.
- The team will follow-up in writing on a referral form that may include the following:
  - Recipient name, address, phone number, date of birth and Medicaid ID number
  - Primary physician name and phone number
  - Primary diagnosis and diagnosis code

Referral Form cont.

- Date services are to begin and frequency.
- Which service to be provided with procedure code and modifier.
- Number of units/dollars in prior authorization.
- Prior authorization number that must be on all claims.
- Date span of prior authorization.

Most Common Denial Reasons

- Prior authorization number is missing or invalid.
  - Verify PA number is on the claim.
  - Verify PA number with referral form.

Most Common Denial Reasons, cont'd.

- Payment denied/reduced for absence of, or exceeded authorization.
  - Units/dollars on claim are greater than the PA
    - Check previous claims for over billing
    - Call case management team
  - Procedure code on claim is not in the PA
    - Check claim to see if procedure code is correct with referral. If correct, call case management team.

Most Common Denial Reasons, cont'd.

- Payment adjusted because the recipient has not met the required eligibility requirements.
  - Recipients have subtypes within the Medicaid eligibility system. At the time the claim was processed, the recipient's subtype was not HCBS.
  - Claims are suspended and sent to DPHHS for approval.
    - If recipient is HCBS, claim is approved.
    - If recipient is not HCBS on date of service, claim is denied.
      - Check date span of recipient's HCBS eligibility with case management team.

Most Common Denial Reasons, cont'd.

- Payment is adjusted when billed by this type of provider.
  - Many HCBS providers are also other Medicaid provider types. For example:
    - DME
    - Personal Assistance Services
    - Therapists and counselors
    - Nursing Facilities
  - Make sure you are billing with your HCBS provider number.

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Who to Contact

Home and Community Based Services Policy Questions:

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Questions???